AIG

Student Health Insurance Plan ("the Plan")

University *of* New Haven

("the Policyholder")

2014-2015

Insurance Underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY
("the Company")

Administrator Policy # CHH8050545
Underwriter Reference # CAS9497181

NOTE

The policy on file at the University contains all of the definitions, reductions, limitations, exclusions and termination provisions, some of which may not be included in this brochure. Full details of coverage are contained in the Policy. If any discrepancy exists between this brochure and the Policy, the Policy will govern. Travel Assistance services provided by Travel Guard. Insurance and services provided by member companies of American International Group, Inc. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.

ELIGIBILITY

All full time undergraduate students and full time international graduate students taking 12 or more credits at the University of New Haven will be automatically enrolled in the Plan and the cost for the coverage will be added to the student's account unless a waiver showing proof of comparable coverage is furnished by the waiver deadline. To waive, coverage under the Plan, students must complete the Online Waiver Form at **www.BollingerColleges.com/unh by September 5, 2014** for the Annual Semester term of coverage and **January 31, 2015** for the Spring Semester term of coverage.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility under another creditable coverage. If you experience ineligibility under another creditable coverage, please email proof of ineligibility to Colleges@Bollinger.com.

Full time domestic graduate students are eligible to enroll in the Plan on a voluntary basis. Enrollment is only allowed during an open enrollment period. The open enrollment periods deadline dates are **September 5, 2014** for the Annual term of coverage and **January 31, 2015** for Spring Semester term of coverage. **To enroll, please contact the Bursar's Office.**

An eligible student must actively attend classes at the University for at least the first 30 days of the period for which he or she is enrolled. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 30 days of the period for which he or she is enrolled will not be covered under the Plan and a full refund of premium will be made less any claims paid. Students who withdraw after such 30 days will remain covered under the Plan and no refund will be made. The Company maintains the right to investigate student status and attendance records to verify that Policy eligibility requirements have been met. If it is discovered that Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

Eligible students may also enroll their eligible dependents. An eligible dependent is the Covered Student's spouse residing with the Covered Student and the Covered Student's child until the date such child attains age of 26, provided such child is not provided coverage under a group health plan through his or her own employment. A dependent may become eligible for coverage under the Plan only when the student becomes eligible. **To enroll, please contact the Bursar's Office.**

COST OF INSURANCE*

Term of Coverage	Annual 8/1/14 – 8/1/15	Spring/Summer 1/1/15 – 8/1/15
Full time Undergraduate/International Graduate Students	$1,491	$874
Full time Domestic Graduate Students	$2,262	$1,326
Each Dependent	$2,065	$1,210

*includes taxes and administrative fees

EFFECTIVE DATES AND TERM OF COVERAGE

The Policy becomes effective at 12:01 a.m. on August 1, 2014 and will terminate at 12:01 a.m. on August 1, 2015. The coverage of an eligible student, including the student who initially waived coverage and subsequently enrolls within 31 days of ineligibility under another creditable coverage, shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Company; (3) the date the Policyholder's term of coverage begins; or (4) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder.

A full time domestic graduate student who does not enroll himself or herself during an open enrollment period may not apply for coverage until the next subsequent open enrollment period unless application for coverage is made within 31 days of ineligibility under another creditable coverage. As a result of ineligibility under another creditable coverage, the Student may enroll for coverage for himself or herself. In that case, the insurance for the eligible student becomes effective on the latest of the following dates: (1) the day after the date on which the first premium for the Covered Student's coverage is received by the Company; or (2) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder.

Insurance for a Covered Student will end at 12:01 a.m. on the first of these to occur: (a) the date the Policy terminates; (b) the last day for which any required premium has been paid; or (c) the date on which the Covered Student withdraws from the school because of: (1) entering the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made within 90 days of leaving school); (2) withdrawal from school during the first 30 days of the period for which enrollment was made; or (3) departure from the Policyholder's school for his or her home country. Premiums will be refunded on a pro-rata basis only upon written proof from the Policyholder that the Covered Student is no longer an eligible person.

If withdrawal from school is for other than (1), (2) or (3) above, no premium refund will be made. Students, including those who withdraw from school during the first 30 days due to Injury or Sickness, will be covered for the Policy term for which they are enrolled and for which premium has been paid.

Except as specifically provided in the Policy, insurance for a Covered Student's dependent will end when insurance for the Covered Student ends.

EXTENSION OF BENEFITS

If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of the Hospital confinement, including supplies and professional services rendered during such confinement. Such benefits will be payable until the earliest of: (1) the date the Covered Person is discharged from the Hospital; (2) the end of the 31 day period following the date his or her coverage terminated; or (3) the date the applicable maximum amount is reached.

IN THE EVENT OF PREGNANCY. If a Covered Person is pregnant on the date the Policy terminates and that pregnancy commenced while the Policy was in force, benefits for such pregnancy will be payable for Eligible Expenses incurred for which benefits would have been payable had the Policy remained in force.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

DEFINITIONS

"**Accident**" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

"Act" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

"Allowable Charges ("AC")" means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

"Covered Percentage" means the percentage of the Eligible Expense that is payable as a benefit under the Policy.

"**Covered Person**" means a Covered Student while coverage under the Policy is in effect and those dependents with respect to whom a Covered Student is insured.

"**Covered Student**" means a student of this Policyholder who is Covered Person under the Policy.

"**Deductible/Deductible Amount"** means the dollar amount of Eligible Expenses a Covered Person must incur during each Policy Year before benefits become payable.

"**Doctor**" as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's immediate family member.

"Eligible Expense" as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) in the event a co-pay amount applies within the benefit structure, the actual charge; or (c) not in excess of the charges that would have been made in the absence of this coverage; (d) is the negotiated rate, if any; and (e) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

"**Emergency Medical Condition**" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the life or health of the person afflicted with such condition or, with respect to a pregnant woman, the life or health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to such person's bodily functions; or (c) serious dysfunction of any bodily organ or part of such person. When an Emergency Medical Condition occurs, the Covered Person may use the 9-1-1 emergency system or any other telephone access system that is used to access pre-hospital emergency services when the Covered Person is confronted with a life or limb threatening emergency. If such is the case, the Covered Person shall not be required to obtain approval from the Company or Policyholder prior to calling 9-1-1.

"Life or Limb threatening emergency" means any event which the Covered Person believes threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

"Emergency services" means the following:

(a) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;

(b) such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

"Essential Benefits" means the essential health benefits defined in Section 1302(b) of the Act. This includes at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services;
(B) Emergency services;
(C) Hospitalization;
(D) Maternity and newborn care;
(E) Mental health and substance use disorder services, including behavioral health treatment;
(F) Prescription drugs;
(G) Rehabilitative and habilitative services and devices;
(H) Laboratory services;
(I) Preventive and wellness services and chronic disease management;
(J) Pediatric services, including oral and vision care.

"**Hospital**" means a facility which meets all of these tests:
(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; or (c) as a place for custodial or educational care. The term "Hospital" includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; (c) a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Mental Retardation; and (d) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; and (b) occurs the Policy is in force as to the person whose Injury is the basis of claim. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

"Medical Necessity/Medically Necessary" means health care services that a Doctor, exercising prudent clinical judgment, would provide to a Covered Person for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury, or disease or its symptoms, and that are:
(a) in accordance with generally accepted standards of medical practice;
(b) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Covered Person's illness, Injury or disease; and
(c) not primarily for the convenience of the Covered Person, Doctor or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, Injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

"Preventative Benefits"
Coverage for preventative benefits, as defined in the Act, do not require payment of any deductible, copayment, or coinsurance.

"**Reasonable and Customary ("R&C")**" means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

"Geographic area" means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

"**Sickness**" means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

FIRST HEALTH PREFERRED PROVIDER NETWORK

Covered Persons insured under the Plan may choose to be treated within or outside of the First Health Preferred Provider Organization ("PPO"). Reimbursement rates will vary according to the source of care as described under the Schedule of Benefits. Assignment of a PPO Provider does not guarantee eligibility or right to student health benefits. **It is the Covered Person's responsibility to verify that a provider is a participating provider prior to services being rendered.** Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or the facility to which the Covered Person is referred is also a PPO provider. For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the Out of Network level. If treatment or care is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the In Network level. Benefits payable under the Plan for covered services rendered through the PPO network shall be based on the Allowable Charges of its providers. Benefits payable under the Plan for covered services rendered outside the PPO network shall be based on the Reasonable and Customary charges of the providers, except in the case wherein a co-pay amount is included in the benefit structure, the actual charge. To locate a PPO Provider please call1-800-226-5116 or visit www.MyFirstHealth.com.

STUDENT HEALTH SERVICES REFERRAL PROCEDURE - STUDENTS ONLY

In the event of Sickness or Injury, the Covered Student should report to Student Health Services for treatment or referral. This provision does not apply if: (a) the Student Health Services is closed (b) covered service is rendered at another facility during school breaks or vacation times; (c) medical care is received when Student is more than 50 miles from campus ; (d) medical care is obtained by a Student who is not eligible to use the Student Health Services; (e) for any gynecological examination or care related to pregnancy, including primary and preventive obstetric and gynecologic services required as a result of any gynecological examination or as a result of a gynecological condition; (f) for mental and nervous conditions; or (g) the Student Health Services cannot provide the needed medical care. Emergency Medical Condition will be payable at the PPO level whether received from a PPO provider or non-PPO provider. This provision does not apply to the Covered Student's dependents.

The Deductible Amount will be waived when, for Covered Students Only, a referral is made by a Student Health Service Doctor. The applicable Deductible shall apply to all of the exceptions to the referral provision shown above.

SCHEDULE OF BENEFITS

	IN NETWORK	OUT OF NETWORK
Aggregate Maximum Amount per Policy Year	Unlimited	

Out-of-Pocket Maximum: $5,000 Per Covered Person per Policy Year / $10,000 Per Family Per Policy Year

This is a benefit that will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit shown above. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable due to Covered Percentages less than 100%. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary; expenses incurred for prescription drugs; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy.

When this benefit becomes applicable to a Covered Person during a Policy Year, Covered Percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person for the remainder of that Policy Year up to any benefit maximum that may apply.

Deductible Amount per Policy Year	$100	$200

INPATIENT BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
Daily Room & Board Expense, semi-private room rate.	80% of AC	60% of R&C
Miscellaneous Hospital Expense, includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays, (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses.	80% of AC	60% of R&C
Physiotherapy	80% of AC	60% of R&C
Surgical Expense	80% of AC	60% of R&C
Anesthetist	80% of AC	60% of R&C
Doctor's Visits (Doctor other than a Doctor who performed surgery or administered anesthesia)	$25 co-pay / 80% of AC	$25 co-pay / 60% of R&C
Medical Complications of Alcoholism	Same as any other Sickness	Same as any other Sickness
Mental or Nervous Conditions Expense	80% of AC	60% of R&C

OUTPATIENT BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
Day Surgery Facility / Miscellaneous, when scheduled surgery is performed in a Hospital/outpatient facility/ambulatory surgical center, including use of operating room, x-ray examinations and laboratory tests (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding physiotherapy or take home drugs and medicines)	80% of AC	60% of R&C
Surgical Expense	80% of AC	60% of R&C

Anesthetist	80% of AC	60% of R&C
Doctor's Visits (Not applicable when surgery is performed)	$25 co-pay / 80% of AC	$25 co-pay / 60% of R&C
Hospital Emergency Room/Non-Scheduled Surgery	80% of AC	80% of R&C
Urgent Care	80% of AC	60% of R&C
Skilled Nursing Facility	Same as any other Sickness	Same as any other Sickness
Rehabilitative Care (physical therapy, occupational therapy, cardiac/pulmonary, inhalation therapy)	80% of AC	60% of R&C
Laboratory and X-rays Examinations	80% of AC	60% of R&C
CAT Scan/MRI	80% of AC	60% of R&C
Radiation Therapy and Chemotherapy	80% of AC	60% of R&C
Prescribed Medicines Expense – prescriptions should be filled at a Catamaran participating pharmacy. For a list of nationwide participating pharmacies, please visit www.mycatamaranrx.com. Benefits are also payable for prescribed contraceptive methods approved by the FDA. As specified by PPACA, co-pay amounts will be waived for prescribed FDA-approved birth control.	Co-pay per prescription – limited to a 30 day supply: $15 Generic $35 Formulary Brand Name $40 Non-Formulary Brand Name	
Medical Complications of Alcoholism	Same as any other Sickness	Same as any other Sickness
Mental or Nervous Conditions Expense	80% of AC	60% of R&C
OTHER SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Pediatric Dental Treatment Expense (for Covered Persons under age 19)	One basic oral exam and two routine cleanings including topical fluoride every six month. Payable at 100% up to a $10,000 maximum.	
Vision Care Expense	One basic exam and one pair of glasses (lenses and frames) per year payable at 80%.	
Preventive Benefits	100% of AC (not subject to the deductible)	60% of R&C
Ambulance Services Expense	100% of the actual charge up to the maximum allowable rate established by the Department of Public Health	
Consultant's Fees Expense (must be requested and ordered by the attending Doctor)	80% of AC	60% of R&C
Durable Medical Equipment and Orthopedic Appliance	80% of AC	60% of R&C
Dental Treatment (Injury Only) : $500 maximum per Injury	80% of AC	60% of R&C
Maternity	80% of AC	60% of R&C
Home Health Care Expense	80% of AC	60% of R&C

STATE MANDATED BENEFITS

The Plan also covers all applicable mandated benefits as required by the State of Connecticut. Please see the Policy on file with the University for details.

COORDINATION OF BENEFITS PROVISION

The Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverage under which the Covered Person is enrolled shall not exceed 100% of the cost of the covered services.

EXCLUSIONS

The Plan does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment, except as provided elsewhere in the Policy.

2. for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder.

3. for eye examinations, eyeglasses, contact lenses, or prescription for such; radial keratotomy or laser surgery; hearing aids for Covered Persons over the age of 12; except as provided under the Policy.

4. for hearing examinations or hearing aids. This exclusion will not apply with respect to hearing aids for a Dependent child twelve (12) years of age or younger.

5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.

6. for Injury or Sickness resulting from war or act of war, declared or undeclared.

7. as a result of an Injury or Sickness for which the Covered Person is provided benefits under any Workers' Compensation, employers' liability or Occupational Disease Law. This exclusion shall not apply to the bodily Injury of the Covered Person solely because it was caused by an Accident arising out of and in the course of employment to a Covered Person who is: (a) sole proprietor or business partner who is not covered by the provisions of chapter 568 or who accepts the provision of said chapter 568 pursuant to subdivision (6) of section 31-275; or (b) an employee of a corporation and who is a corporate officer.

8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country or units auxiliary thereto. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.

9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance. This exclusion shall not apply with respect to treatment rendered in the Veterans Home or Hospital.

10. for cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment within twenty-four (24) hours of the Accident. Correction of deviated nasal septum shall be considered as cosmetic surgery for the purpose of the Policy.

11. as a result of participation in a riot or civil commotion. This exclusion does not apply with respect to health care services rendered to treat any Injury sustained by a Covered Person when such Injury is alleged to have occurred or occurs under circumstances in which (a) such Covered Person has an elevated blood alcohol content, or (b) such Covered Person has sustained such Injury while under the influence of intoxicating liquor or any drug or both. "Elevated blood alcohol content" means a ratio of alcohol in the blood of such Covered Person that is eight-hundredths of one per cent or more of alcohol, by weight.

12. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

13. for any services rendered by a Covered Person's immediate family member.

14. for a treatment, service or supply which is not Medically Necessary.

15. as a result of suicide (sane or insane), attempted suicide or intentionally self-inflicted Injury except in conjunction with and as a result of a diagnosed mental or nervous condition as defined and covered under the Policy.

16 as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are Covered Persons under this Policy. This exclusion does not apply with respect to health care services rendered to treat any Injury sustained by a Covered Person when such Injury is alleged to have occurred or occurs under circumstances in which (a) such Covered Person has an elevated blood alcohol content, or (b) such Covered Person has sustained such Injury while under the influence of intoxicating liquor or any drug or both. "Elevated blood alcohol content" means a ratio of alcohol in the blood of such Covered Person that is eight-hundredths of one per cent or more of alcohol, by weight.

17. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational. This exclusion will not apply with respect to a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase III clinical trial of the federal Food and Drug Administration.

18. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

SUBROGATION

In the event any payments for benefits provided to a Covered Person are because of an Injury or Sickness caused by a third party's wrongful act or negligence, the Company, to the extent of that payment, will be subrogated to any recovery or right of recovery the Covered Person has against that third party, to the extent permitted by law, provided: (a) the Covered Person is entitled to payment for Hospital, surgical or medical services as the result of a third party settlement or court judgment; and (b) such settlement or judgment specified an amount or portion of payment that represents payment for such benefits; and (c) the Company has paid benefits to the Covered Person under the Policy for the same services or benefits covered by the settlement or judgment.

The Covered Person agrees to make a decision on pursuing a claim against a third party within 30 days of the date the Company requires that the Covered Person provide notice of claim for the Injury or Sickness for which benefits under the Policy are sought and to notify the Company of his or her decision within such 30 day period.

In the event the Covered Person decides not to pursue payment of claim against such third party, the Covered Person: (a) authorizes the Company to pursue, sue, compromise or settle any such payment of claim in the name of the Covered Person; (b) authorizes the Company to execute any and all documents necessary; and (c) agrees to cooperate fully with the Company in the prosecution of any such payment of claim.

If the Company exercises its rights under this provision, it will recover no more than the amount paid under the Policy for such benefits. The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of a Covered Person against any third party or coverage.

The Company's right of subrogation will not be enforced until the Covered Person has been made whole, as determined by a court of law, as a result of injury or Sickness.

TRAVEL GUARD
DESCRIPTION OF TRAVEL ASSIST AND STUDENT ASSIST SERVICES

Procedures on How to Access Travel Guard and Student Assist Services 24-Hour Assistance Call Services

When to Contact Travel Guard:

- Before you incur expenses.
- If you are 100+ miles from home and require medical assistance or have a medical emergency.
- If you are 100+ miles from home and need assistance with a non-medical situation such as lost luggage, lost documents, legal help, etc.

How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.
- Outside the US and Canada:
    - Request an international operator.
    - Ask the international operator to connect to an AT&T operator.
    - Request the AT&T operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 1-262-364-2203.

Travel Guard is available 24-hours-a-day/7-days-a-week/365-days-a-year. Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help participants should the need arise while traveling. The Travel Guard Medical Staff consists of full-time, on-site Registered Nurses and Emergency Doctors who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a Doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide when you call:

- Advise Travel Guard your insurance company name.
- Provide your Policy Number or School Name.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

Description of Services

General Information: Services listed below include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available
currency exchange rates, local Bank/Government holidays, and by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

- Visa & Immunization
- Weather & Exchange Rates

Technical: Services listed below include assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter en route emergencies that force them to interrupt their trips.

- Legal Referral
- Lost/Stolen Luggage Information
- Claims-related Assistance & Personal Effects Assistance
- Lost Document Assistance & Cash Transfer Assistance
- Embassy/Consulate Information
- Telephone Interpretation
- Enroute Travel Assistance

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains and insurance claims coordination.

Medical Assistance:
- Medical Referral
- Out-patient Assistance
- In-patient Assistance

Medical Transport:
- Evacuation
- Repatriation of Remains

REPATRIATION AND MEDICAL EVACUATION BENEFITS

(Benefits for Repatriation of Mortal Remains and Medical Evacuation are provided by National Union Fire Insurance Company of Pittsburgh, Pa.)

REPATRIATION OF REMAINS: $10,000 Maximum Amount
If a Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of Primary residence, but not exceeding the Maximum Amount per Covered Person.

Eligible Expenses include, but are not limited to: (1) embalming or cremation: (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

MEDICAL EVACUATION: $10,000 Maximum Amount
The Company will pay, subject to the limitations set out herein, for eligible Medical Evacuation expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Medical Evacuation while outside his or her home country but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes. The Doctor ordering the Medical Evacuation must certify: (a) that the severity of the Covered Person's Injury or emergency Sickness warrants his or her Medical Evacuation; and (b) the Covered Person has been Hospital confined for at least five (5) consecutive days prior to Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions.

STUDENT ASSIST SERVICES

Concierge Services: You receive the comfort, care, and attention of Travel Guard's Personal Assistance Coordinators available 24/7 to respond to virtually any request — large or small.
Personal Security Assistance: You can feel safe and secure with Travel Guard's Personal Security Assistance at home or while traveling. To activate personal security services, please log onto http://aig.com/travelguardassistance.

To register:
(1) Click on "Sign In" in the upper right-hand corner.
(2) Click on "Register Here".
(3) Complete required fields: first name, last name, email address, policy number 9497181 and then click "Submit."

AMERICAN HEALTH HOLDING, INC.

24-HOUR STUDENT EMERGENCY CARE HOTLINE

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free (866) 315-8756
(American Health Holding, Inc. is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

Comprehensive Resources and Advice from Registered Nurses
- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.

- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.

- Integrated phone access to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse.

CLAIM PROCEDURE

In the event of an Injury or Sickness, the Covered Person should:

1. Notify Bollinger, Inc. within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible. Complete the Bollinger claim form in full and sign it. Mail a copy to Bollinger, Inc., PO Box 727, Short Hills, NJ 07078-0727.
2. Claim forms are available online at www.BollingerColleges.com/UNH or by calling 855-338-8015. If the providers have given you bills, please keep a copy and attach them to the claim form.
3. Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Bollinger, Inc. Online claim status is available at www.BollingerColleges.com/UNH or by calling 855-338-8015.
4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to Bollinger.

Written proof of loss must be given to the Company within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

SUBMIT ALL CLAIMS TO:

Bollinger Specialty Group
BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.
P.O. Box 727
Short Hills, NJ 07078-0727
855-338-8015

PREFERRED PROVIDER NETWORK:

First Health Network

www.myfirsthealth.com